



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

**Requestor Name**

MEDME Services Corporation

**Respondent Name**

Ace American Insurance Co

**MFDR Tracking Number**

M4-14-2380-01

**Carrier's Austin Representative**

Box Number 15

**MFDR Date Received**

April 1, 2014

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "The disputed fees should be paid because supplies are only included with the rental of the TENS unit not the purchase. The unit was purchased a month after rental therefore additional supplies were required for the continued operation of the TENS unit."

**Amount in Dispute:** \$273.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** Written acknowledgement of medical fee dispute received however, no position statement submitted.

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 28, 2013	A4595	\$273.00	\$117.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 468-002 Supplies for purchased tens unit are allowed only after 30 days from the date of purchase
  - 193 - Original payment decision is being maintained

**Issues**

1. Did the requestor support the services are payable as billed?
2. Is the requestor entitled to reimbursement?

## **Findings**

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged, received on April 9, 2014. The insurance carrier did not submit a response for consideration in this review. Per the Division's former rule at 28 Texas Administrative Code §133.307(d)(1), effective May 25, 2008, 33 *Texas Register* 3954, "If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information." Accordingly, this decision is based on the available information.
2. The carrier denied the disputed services as, 468-002, "Supplies for purchased tens unit are allowed only after 30 days from the date of purchase." Per 28 Texas Administrative Code §134.203 (b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules. Per [www.cms.hhs.gov](http://www.cms.hhs.gov). Local Coverage Determination (LCD) ID L5031, LCD Title Transcutaneous Electrical Nerve Stimulators (TENS); Separate allowance will be made for replacement supplies when they are reasonable and necessary and are used with a covered TENS. Usual maximum utilization is: 2 TENS leads - a maximum of one unit of A4595 per month, 4 TENS leads - a maximum of two units of A4595 per month." "Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. Suppliers must stay attuned to changed or atypical utilization patterns on the part of their clients. Suppliers must verify with the ordering physicians that any changed or atypical utilization is warranted. Regardless of utilization, a supplier must not dispense more than a 3-month quantity at a time."

Review of the submitted documentation finds a statement from the requestor, "The unit was purchased a month after rental therefore additional supplies were required for the continued operation of the TENS unit."

No documentation was found from the respondent to indicate the supplies were not furnished after the unit had been purchased. The services in dispute will be reviewed per applicable rules and fee guidelines.

3. Per 28 Texas Administrative Code §134.203(d) The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; The Fee schedule allowable is  $\$31.20 \times 125\% = \$39.00$  per unit  $\times 3$  (maximum amount allowed per Medicare) = \$117.00. This amount is recommended.

## **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$117.00.

## **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$117.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

## **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
November , 2014  
Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**